The government lie and cover-up leading to needless infection, illness and death.

The Covid Airborne Transmission Alliance (CATA), core participants in Module 3 of the UK Covid Inquiry, have continued, since the conclusion of Module 3, to work through the evidence provided to the Inquiry to identify gaps and inconsistencies in the evidence, with particular relation to scientific decision making and the role of the IPC Cell.

This has been a very intensive process, but it has identified some significant areas where verbal evidence to the Inquiry is inconsistent in material way with other evidence, especially evidence that has not been made available to the Inquiry.

Using approaches, including Freedom of Information requests, CATA has given the Inquiry additional information and evidence which explains, casts new light, or undermines evidence provided.

CATA submitted two reports to Baroness Hallett on 6th March 2026.

The reports are based on research (a) via documents disclosed on 'Relativity' (limited to module 3, the only module for which CATA was granted CP status) and (b) Freedom of Information requests.

CATA has unearthed new evidence (via FoI) strongly suggesting that a significant amount of important information has been withheld from the Inquiry (by UKHSA, NHS-England, DHSC and HSE). CATA's FoI investigations began in March 2020 and have been resisted and obstructed by the above-mentioned authorities.

It is unfortunate that CATA was forced to deliver their reports so close to the M3 publication date. Despite the statutory requirement to respond within 20 working days, it has taken over two years to resolve some of their requests, requiring intervention by the Information Commissioner. Two enforcement notices ('Decision Notices') have been issued by the Information Commissioner against UKHSA (Link 1, Link 2). UKHSA has still not complied with the second of these which concerned why, at a pivotal moment during the second wave (December 2020), Public Health England senior management suppressed their own IPC expert team's recommendation for wider use of respirators to all patient-facing healthcare workers. An important FoI to HSE also remains outstanding since July 2025.

CATA had hoped to complete this 'missing link in the jigsaw' before submitting their report but, with the need to submit it to the Inquiry before the 19th, they have been run out of time.

CATA has invited the Inquiry to investigate the failure to disclose key documents to the Inquiry since (a) it represents a potential offence by State organisations or individuals under section 35(3)(a) of The Inquiries Act 2005, and (b) the Inquiry's findings, conclusions and recommendations in its Module 3 report will be incomplete and may therefore be flawed if it has not been able to consider important and relevant evidence which has been concealed from it by State bodies.

Introduction

In March 2020, the Government took a decision to assert that SARS-CoV-2, the virus that causes Covid-19, was spread by droplet rather than aerosol in order to allow themselves to mandate fluid-resistant surgical masks (FRSMs) for healthcare workers instead of the legally required filtering face pieces (FFP3s), stocks of which were dangerously low at the time.

Late on 12th March 2020, an official alert was posted to the NHS Central Alerting System (CAS) which ordered the down grade of the face masks used as part of personal protective equipment (PPE) for Covid-19 from FFP3 to FRSMs across the NHS.

History may record this as the most damaging single moment in the history of the NHS in terms of subsequent healthcare worker death and chronic disease. The storm of concern, fear and anguish which erupted in the days, weeks, months and years since that fateful mouse-click to post the CAS notice is another story.

The Government's March 2020 decision, re the PPE to be used in the Covid-19 pandemic, the clandestine manner in which it was taken, its subsequent cover-up, that it was never revoked despite many opportunities to do so, and its continuation by the current Government, is a scandal of enormous proportions.

Healthcare workers were knowingly lied to about the protections they were afforded against Covid-19. It is accepted that something had to be done over the short-term to deal with the shortage of FFP3s, but deliberately lying to healthcare workers most certainly wasn't the correct legal nor ethical solution. And the implications of this single decision have had far-reaching and fatal consequences which persist to the current day.

The lie was driven by individuals in the 4-Nations IPC (Infection Prevention and Control) Cell whose role was to protect healthcare workers and patients in healthcare settings from the start of the Covid-19 pandemic and supported by many individuals and organisations who led the Government's response to it, including the Health and Safety Executive.

Those that took the initial decision in March 2020 have since doubled down on it, seemingly because to acknowledge now that it should have only been a temporary decision taken because of short-term extraordinary circumstances would be to acknowledge mistakes and failings, and damage reputations and career. And acknowledge avoidable deaths. And most likely would open the Government up to litigation.

There has been a cover-up of extraordinary proportions that continues to this day.

Three Reports that tell the story in referenced detail

Two wide-ranging reports have been sent to Baroness Hallett, Chair of the UK Covid-19 Inquiry, by CATA (Covid Airborne Transmission Alliance), who were core participants in Module 3 of the Inquiry.

Whilst the decisions taken on that fateful day, 13th March 2020, following the CAS alert issued on 12th March 2020, and the subsequent actions taken by the IPC Cell and other key decision makers were explored to some degree in the public Covid Inquiry hearings, these two reports from CATA take it to a far deeper level and reveal concerning details.

These reports from CATA are the result of hundreds of hours of forensic investigation of the evidence over a 5-year period. Evidence has been pieced together from 17,000 documents disclosed to Core Participants of the Covid Inquiry during the course of Module 3 (Impact of the pandemic on healthcare systems across the UK), together with a number of documents obtained under Freedom of Information (FOI) requests which were used to fill in the missing pieces of the jigsaw. Many of the documents used to compile this report have only ever been released to the Core Participants of the Inquiry and have never been publicly published. Much of the content of these reports has been buried… until now.

One of the CATA reports is an updated version of a report previously submitted to the Inquiry, called *Changes in the Management of COVID-19 13th March 2020*. This report was first submitted to the Covid-19 Inquiry on 31st July 2024 with the expectation that the Inquiry Team would disclose it to all core participants (CPs). They didn't. It had been hoped that this report would provide all parties with a better understanding of three important events which occurred within a few hours of each other on Friday 13th March 2020, namely:

- The implementation of version 1.0 of the 4-nations Infection Prevention and Control guidance;
- the downgrading of respiratory protection from Respiratory Protective Equipment (RPE) such as FFP3 respirators to the so-called "PPE", namely Fluid Resistant Surgical Masks (FRSM); and
- the declassification of Covid-19 as a High Consequence Infectious Disease (HCID).

It is fully referenced, using documents provided to the Covid Inquiry, witness testimony to the Inquiry as well as documents obtained under Freedom of Information requests and from whistleblowers. The report gives a comprehensive account of the covert machinations that led to the disastrous decision.

The second report by CATA provides a comprehensive analysis of the conduct of the 4-Nations IPC Cell and their cover-up of the March 2020 decision.

Supplies of FFP3s had resumed ahead of the second Covid wave later in 2020. This should have been a moment for reflection and re-evaluation, yet the 4-Nation IPC Cell chose to maintain their guidance issued in the March to mandate the illegal FRSMs as PPE for healthcare workers.

Between December 2020 and June 2022, the IPC Guidance and the evidence for its veracity were challenged on at least seven occasions, including by PHE, SAGE, the four UK Chief Nursing Officers and at a large meeting with healthcare stakeholders. Each time, these challenges were rebuffed by the insistence that SARS-CoV-2 is spread by droplet not aerosol, and thus the flawed IPC Guidance of March 2020 was maintained – despite continued infections of HCWs with Covid-19.

In the second report, there are multiple examples of deceit, collusion and a conspiracy to cover up the original disastrous decision of March 2020, including withholding relevant documents and key evidence from the UK Covid-19 Inquiry, minutes of meetings being altered after the event and lies being told, including under oath to the Covid-19 Inquiry by senior figures. All to protect reputations as healthcare workers were repeatedly infected with an avoidable and preventable airborne virus.

Even the Health and Safety Executive colluded with the IPC Cell to enable them to mandate the illegal FRSMs as PPE. Extraordinarily, the HSE accepted direction to regard the 4-Nations IPC Guidance as the definitive standard against which they should regulate as opposed to the law of the land, including Control of Substances Hazardous to Health (COSHH) legislation. And they helped write a Q&A that helped the IPC Cell 'sell' the downgrade of PPE to healthcare workers, even though the PPE was illegal under the very legislation the HSE is supposed to uphold.

The IPC Cell seemed to be driven by their adherence to the approach as expressed by one of the original decision-makers in September 2020: *"if you wanted to change the guidance itself, it would need a very careful narrative, as it would be easy to give the impression that we got it wrong the first time when it is something we collectively signed off on"*.

The two reports were sent to Baroness Hallett on 6th March 2026. CATA has also sent both reports to all Core Participants for Module 3 of the UK Covid-19 Inquiry who have signed the legal undertaking of confidentiality.

CATA are also making available to journalists redacted versions of both their reports, with information taken from confidential documents disclosed by the UK Covid-19 Inquiry to Module 3 Core Participants removed.

Link 1: Changes in the Management of COVID-19 (March 2020)

Link 2: Independent Investigation into the conduct of the IPC Cell

The third report is an analysis by campaigner Alan Barnard of letters sent by DHSC Ministers and others to Members of Parliament which support and maintain the disastrous IPC Cell Guidance and the decision-making upon which it was based despite overwhelming evidence that that decision was flawed. Government Ministers have written to other MPs as recently as April 2025 maintaining the lie of March 2020. There are four known letters, but it is expected there will be others.

The third report explains the science and the evidence that expose three of the four DHSC letters as being written to maintain the March 2020 decision and rationale. It is thought that these three letters were authored by a member of, or someone close to, the IPC Cell that has driven the cover-up since 2020.

This analysis was prepared for information and to record how the Government continues to argue that Covid-19 is not spread through airborne means. It has not been presented to the Covid-19 Inquiry. It is available in full.

When read together, these three documents provide a coruscating exposé of known failure to protect healthcare workers and a deliberate, ongoing cover-up of a decision that cost many thousands of lives.

Five important things to note

1.
In January 2020, Covid-19 was classified as a High Consequence Infectious Disease (HCID) spread by the airborne route.

2.
In November 2020, the Government released a video to the public highlighting how coronavirus lingers in the air. It was part of their 'Hands, Face, Space' campaign and explains that "Coronavirus is spread through the air via large droplets & smaller particles. Lighter coronavirus particles float in the air. They can linger in a room or any enclosed space."

3.
Fluid-resistant surgical masks (FRSMs) are not legal personal protective equipment (PPE) within the meaning of UK law under the Control of Substances Hazardous to Health (COSHH) 2002 or Personal Protective Equipment legislation 1992, 2002, 2020. Although they do provide a physical barrier to large droplets, FRSMs do not provide respiratory protection against smaller droplets and aerosols, which is how SARS-CoV-2 is largely spread.

Legally, health and safety legislation, the COSHH regulations, has pre-eminence over any guidance in the National Infection Prevention and Control (IPC) manuals.

4.
A paper, 'Guidance on the use of respiratory and facial protection equipment', co-authored by Lisa Ritchie and Jonathan Van Tam, key players in the story that follows, was published in the Journal of Hospital Infection, Volume 85, Issue 3, November 2013. This paper advised on the difference types of PPE, and which should be used for airborne diseases:
https://www.sciencedirect.com/science/article/pii/S019567011300279X

These are extracts from it concerning FRSMs and FFP3s:

> *Surgical face masks provide a barrier to splashes and droplets impacting on the wearer's nose, mouth and respiratory tract. They do not provide protection against airborne (aerosol) particles and are not classed as RPE. Whilst some surgical masks claim to have particulate filtration properties, they do not have the filtering efficiencies required for adequate respiratory protection. Moreover, most are not designed to fit closely to the wearer's face, and the poor fit means that aerosols can be inhaled having passed through the gap between the mask and the wearer's face, escaping any filtration.*
>
> *A respirator is used by an individual to provide respiratory protection.*
> *FFP3 is the only FFP class acceptable to HSE for use against infectious aerosols in health care in the UK*

Available online at www.sciencedirect.com

Journal of Hospital Infection

journal homepage: www.elsevierhealth.com/journals/jhin

Guidelines

Guidance on the use of respiratory and facial protection equipment

J.E. Coia [a,*], L. Ritchie [b], A. Adisesh [c], C. Makison Booth [c], C. Bradley [d], D. Bunyan [b], G. Carson [e], C. Fry [f], P. Hoffman [g], D. Jenkins [h], N. Phin [g], B. Taylor [i], J.S. Nguyen-Van-Tam [j], M. Zuckerman [k], The Healthcare Infection Society Working Group on Respiratory and Facial Protection

Surgical face mask

Surgical face masks provide a barrier to splashes and droplets impacting on the wearer's nose, mouth and respiratory tract. They do not provide protection against airborne (aerosol) particles and are not classed as RPE. Whilst some surgical masks claim to have particulate filtration properties, they do not have the filtering efficiencies required for adequate respiratory protection. Moreover, most are not designed to fit closely to the wearer's face, and the poor fit means that aerosols can be inhaled having passed through the gap between the mask and the wearer's face, escaping any filtration. Although not classified as RPE, surgical face masks used for protection against infection must be fluid repellent, compliant with the Medical Devices Directive (MDD 93/42/EEC),[10] and be 'CE' marked.[11] Some surgical masks have integral eye protection.

Surgical masks should be worn for the duration of the relevant exposure, task or procedure. They should be changed if they become damaged or contaminated with respiratory secretions, only worn once, and discarded as healthcare waste following use.

Respirator

A respirator is used by an individual to provide respiratory protection. In the healthcare setting, this most commonly relates to the filtering half face mask. The European standard for filtering face masks [EN 149 (currently 2009)] lists three classes of filtering face piece (FFP): FFP1, FFP2 (approximately equivalent to N95) and FFP3.[5] These are classified by inward leakage in laboratory tests and simulated real-life use. Inward leakage can result from penetration through the material matrix of the face piece or through any gap between the face piece and the wearer's face (see Appendix 1 'fit testing'). FFP3 offers the highest level of protection. Although most of the evidence base supporting the use of FFP respirators in the prevention of airborne transmission of infection is based upon N95/FFP2 devices, FFP3 is the only FFP class acceptable to HSE for use against infectious aerosols in health care in the UK (Appendix 3). In the USA, N95 (approximately equivalent to FFP2) is acceptable, as is the case in a number of other countries.

5.

The refusal to acknowledge airborne spread has meant there has never been any focussed efforts on preventing airborne transmission in healthcare. Improvements to ventilation and air cleaners have never been prioritised, nor have newer technologies such as far-UVC germicide, because flawed IPC Guidance has focussed only on droplets and thus citizens worrying about washing hands to the exclusion of understanding the quality of the air we breathe. It has resulted in airborne infections spreading and a complete lack of airborne mitigations being developed for use in wiser society including in schools, where so many illnesses are spread.

The Original Sin – a summary of CATA's first report

The undercover decision of March 2020, the original sin that has led to the cover-up, was possibly the single worst, most consequential, decision taken in the history of the NHS. Many healthcare workers died, and many more have earlier onset chronic health conditions as a result. And there were knock-on impacts too, with healthcare workers passing it on to other patients, to their families and into the community.

With almost a quarter of a million UK citizens now dead, and maybe several million with earlier onset chronic health conditions caused by the lingering effects of the SARS-CoV-2 virus, including more than one in three healthcare workers, the implications for litigation are enormous – far in excess of the numbers involved with the Post Office and contaminated blood scandals.

The decision of March 2020, the 'original sin' is explained in a report sent to Baroness Hallett, Chair of the Covid-19 Inquiry, by CATA (Covid Airborne Transmission Alliance), who were core participants in Module 3 of the Inquiry, called *[Changes in the Management of COVID-19 13th March 2020]*. It was first sent to the Inquiry on 31st July 2024, with a request that it be circulated by the Inquiry to all other Core Participants (CPs).

This report was referenced in CATA's Closing Submissions to the UK Covid-19 Inquiry (reference INQ000532408) in order to make others aware of its existence: https://covid19.public-inquiry.uk/documents/inq000532408-module-3-closing-submissions-on-behalf-of-covid-19-airborne-transmission-alliance-cata-undated/

CATA deliberately inserted the following section (3.2) into their Closing Submissions:

> *3.2 The Inquiry has already received a short report by David Osborn of the CATA Executive Team and this will be resent subsequent to these submissions in case it assists the Inquiry. It provides analysis and a timeline of the key decisions which led up to the declassification of Covid-19 as an HCID and the downgrade from FFP3 to FRSM on 13 March 2020. This dispels any remaining uncertainties about this critical waypoint during the pandemic.*

This report was never circulated to the other CPs by the Covid-19 Inquiry, as expected, nor was it made public by the Inquiry. Every request for its release to journalists has been refused to date also.

CATA has now decided to send it to all core participants for module 3 who have signed the Inquiry's legal undertaking: *"In giving this undertaking, I understand that I may only disclose any such documentation and the information it contains to, and discuss it with, the Chair's legal and administrative team and/or other people who have given identical undertakings to the Chair. These people may include my own legal representatives. I acknowledge that it is my responsibility to ensure that any such person has given such an undertaking before discussing and/or disclosing such a document or information to them."*.

In January 2020, Covid-19 was classified as a High Consequence Infectious Disease (HCID) spread by the airborne route. At this time, Professor Jonathan Van-Tam predicted that the isolation wards normally used for HCIDs (e.g. Ebola) would quickly be overrun and that the UK would soon run out of supplies of FFP3 respirators that are legally required to protect healthcare workers (HCWs) from an airborne virus and HCIDs.

By March 2020, stocks of FFP3s were dangerously low and there was always a possibility that HCWs may not show up to work out of fear for their lives and health.

The shortage was caused by the fact that the Government hadn't maintained their emergency pandemic supply of FFP3 respirators. The ones they had were out of date, the straps broke so they had 'catastrophic failures', and the types purchased were only designed, tested and certified to fit a beardless white male face – so no accommodation for the diversity of NHS staff. They couldn't be replenished at the time because the whole world wanted them.

In order to get themselves out of their predicament, the Government decided to use surgical masks for HCWs instead of the legally mandated FFP3 respirators. However, surgical masks are not legal personal protective equipment under the Control of Substances Hazardous to Health (COSHH) 2002 or Personal Protective Equipment legislation 1992, 2002, 2020. And they do not protect against airborne/aerosol pathogens.

Chris Whitty wanted to issue, as a matter of urgency, a new Central Alerting System (CAS) notification to all UK health providers with the updated common, 4-nation PPE guidance authorising the use of FRSMs instead of FFPs. The CAS alert was issued late on 12 March not long after the draft new guidance was sent to Professor Willett.

CAS alert:
https://www.cas.mhra.gov.uk/ViewandAcknowledgment/ViewAlert.aspx?AlertID=102995

However, when the CAS notification was sent out on 12 March, Covid-19 was still classified as an airborne HCID. Thus, the decision to authorise FRSMs was not only in breach of the COSHH regulations but also contravened the specific health and safety rules set by the Health and Safety Executive for HCWs caring for patients with an HCID. This is probably the reason for the reluctance to disclose the 4-nation IPC under FoI when CATA requested it.

Health and Safety rules state that FFP3 had to be used for HCIDs. Regulation 7 of The Control of Substances Hazardous to Health Regulations 2002 mandates unequivocally that "HSE-approved" Respiratory Protective Equipment must be provided where other risk controls are not effective.
https://www.legislation.gov.uk/uksi/2002/2677/regulation/7

This does not include any form of surgical mask which are not legally recognised as PPE in the UK and never have been.
https://www.hse.gov.uk/biosafety/diseases/pandflu.htm#ref15

To justify this change to the prevailing Infection Prevention and Control (IPC) Guidance, the Government came up with a fundamental lie – that Covid-19 was spread by droplet and thus, they said, surgical masks could be used in the place of FFP3s.

The extraordinary machinations around the creation of this lie, that Covid-19 had changed its means of transmission is explained in great detail in CATA's first report.

No credible scientific or technical information has ever been produced by UK Government bodies or WHO to support that Covid-19 was spread by droplet and was not airborne. And it is important to note that after taking evidence from experts, Baroness Hallett confirmed in her

Module 1 report (para 1.12) published in July 2024, *"…the primary routes of transmission for pandemic influenza and coronaviruses are airborne and respiratory…"* https://covid19.public-inquiry.uk/documents/module-1-full-report/

The Government advisers knew this to be the case in March 2020 when they made their decision but lied to get themselves out of a hole. Remember, in January 2020, Covid-19 was classified as a High Consequence Infectious Disease (HCID) spread by the airborne route. The World Health Organisation[1] has stated that no virus currently known has ever changed its route of transmission.

"You will be safe", the Government told HCWs, if you use surgical masks. This wasn't true. And it was illegal. And the Government knew it was.

There are verified stories of doctors wearing surgical masks after the decision was taken, sitting holding the hands of patients as they died of Covid-19. While that was a beautiful, humane response to a dying person when family members were prohibited from visiting, it put the member of staff at huge risk of contracting Covid-19 by breathing in infected air over a prolonged period of time. The doctors thought they were protected by their surgical mask. They weren't, and those who wrote the guidance knew that they weren't.

The cover-up begins – a summary of CATA's second report

The March 2020 decision was taken in a clandestine manner and in an underhand way, and deliberate attempts have been made to keep it under cover ever since.

The cover-up of this decision is explained in a second report sent to Baroness Hallett by CATA, called *[An Independent Investigation into the conduct of the '4-Nations IPC Cell'].* Again, it is fully referenced and comprehensive, using official documents from the Covid-19 Inquiry and obtained through FoIs and from whistleblowers as well as contemporaneous accounts.

It contains information about a number of challenges to the IPC guidance for healthcare workers dealing with Covid-19 patients, and how those challenges were dismissed or ignored, and the means by which the original sin was maintained in the face of new science and better knowledge, all it seems to prevent healthcare workers realising that a knowingly flawed decision was taken in March 2020. It covers the period from December 2020 until March 2022.

The supply of FFP3s resumed before the start of the second Covid-19 wave later in the year. But despite the ready availability of FFP3s since autumn 2020, the illegal mandate of surgical masks has continued to this day.

The March 2020 IPC Guidance, based on a lie, has never been updated because, as one of the original decision-makers said in September 2020: *"if you wanted to change the guidance itself, it would need a very careful narrative, as it would be easy to give the impression that*

[1] WHO also asserted the disease was 'droplet spread' but with no evidence to support that. Of course, the two Governments providing the most financial support to WHO were USA and UK, neither of whom had sufficient respirators to provide 'airborne precautions' (eg FFP3s) – so the disease couldn't possibly be allowed to be considered 'airborne'. The big lie was international as well as national.

we got it wrong the first time when it is something we collectively signed off on". This concern about possible reputational damage if they were to advocate FFP3s was also evident in the minutes of the IPC Cell meeting on 23 December 2020 when a representative from Northern Ireland *"felt that colleagues might think that they have not been appropriately protected with what has been previously recommended"*.

And thus, the cover-up of the fundamental lie began. Because reputations, and probably litigation, were at stake. It has been suggested that this is a scandal bigger than the contaminated blood scandal, with huge financial implications for the Government.

There were seven challenges to the IPC Guidance of March 2020: (1) by PHE members of the IPC Cell at their meetings in December 2020; there was a general groundswell of dissatisfaction with the FRSMs provided as PPE in January 2021; then (2) in April 2021 SAGE accepted airborne transmission when they published a paper called "Masks for Healthcare Workers to mitigate airborne transmission of SARS-CoV-2"; (3) at a healthcare stakeholders' meeting with Government in June 2021; (4) in November 2021 by the four Chief Nursing Officers of the UK; (5) by UKHSA in December 2021; and again by the 4 CNOs in both (6) January 2022 and (7) March 2022.

All of these challenges were rebuffed by the insistence that SARS-CoV-2 is spread by droplet not aerosol, and thus the flawed IPC Guidance of March 2020 was maintained – despite continued infections of HCWs with Covid-19.

This is the Executive Summary of CATA's second report:

> In its opening submission to the Inquiry, CATA pledged to help the Inquiry conduct an effective investigation and assist in uncovering evidence which would enable the Chair to make informed recommendations which would improve the nation's resilience to future pandemics.
>
> In its closing submission we stressed the need for the Inquiry to collate evidence which may determine whether there has been a 'culpable state failure to preserve life' during the pandemic[2]. We also respectfully reminded the Inquiry that, even though it has no power to determine civil or criminal liabilities, it should not be inhibited from determining the facts or making recommendations[3]. This is something that CATA urges the Inquiry to do, for the sake of the countless frontline healthcare workers who have lost their lives or been left with debilitating health conditions.
>
> The litigants in the impending class action depend on it and have a right to it.
> Apart from its written and oral submissions, the CATA Executive Team has conducted extensive investigations of its own. This has taken hundreds of hours of work over five years. This report sets out evidence – in summary:
>
> - state bodies appear to have withheld relevant and important documents from the Inquiry;
> - amendments were made to the minutes of IPC Cell meetings (December 2020), changing 'consensus':
>   - **from** 'precautionary approach' as advocated by PHE (i.e. wider distribution of FFP3 respirators)

[2] Article 2 of the European Convention on Human Rights
[3] Section 2(2) of the Inquiries Act 2005

    - **to** ‘no change to the PPE recommendations in the IPC Guidance’;
- an HSE official’s email to the IPC Cell was deliberately falsified, distorting the intended meaning so as to convey a message supportive of the Cell’s position, then publicly displayed by ARHAI Scotland;
- calling the competence of IPC Cell members into question regarding basic health and safety principles;
- critical of the DHSC handling of a meeting with representatives of over a million healthcare workers:
    - imposing the ‘Chatham House’ rule without prior discussion with stakeholders, evidencing the lack of openness and transparency which pervaded the Government’s handling of the emergency;
    - denying PHE experts the opportunity to participate in the meeting once it was realised that they supported the stakeholders’ position for extending use of FFP3;
    - Concealing key evidence from stakeholders concerning airborne transmission; failing to engage with them to agree the way forward, based on the scientific evidence for airborne transmission and risk management;
- authors of ARHAI ‘Rapid reviews of Literature’ (highly influential on IPC guidance) repeatedly misunderstanding and misrepresenting scientific/research papers, thereby conveying misinformation (arguably disinformation) on the relative efficacy of surgical masks vs respirators;
- some members of IPC cell were more concerned about reputational risks to themselves, losing their independence and concern that PHE might override their fixed views on transmission and PPE;
- The Health and Safety Executive turned its back on the healthcare sector, abrogating its statutory duties to ensure that employers protected the safety of their employees. Instead of enforcing statutory health and safety provisions it enforced compliance with IPC guidance which it knew, or should have known, exposed healthcare workers to mortal danger by inhalation of aerosolised SARS-CoV-2 virions;
- Our findings expose multiple failings across Government; a lack of effective governance over IPC and health & safety arrangements and weak leadership;
- Key decisions were made on the basis of dubious computer modelling and ‘rapid literature reviews’ rather than extant knowledge and straightforward common sense. Experts were appointed who lacked expertise.
- We find the most unforgivable aspect of the pandemic has been how the personal views, opinions and objectives of a relatively small number of individuals in senior positions of authority ignored the chorus of concern from stakeholder organisations about the inadequacy of the PPE requirements of IPC guidance which was plain to see;
- The attempts by state bodies to frustrate our investigations via Freedom of Information requests, together with the evidence produced by those requests strongly suggest an orchestrated cover-up on an astronomical scale;

- Prima-facie evidence is presented in this report of offences having being committed under criminal law, public law (the Inquiries Act) and civil law, the tort being a gross failure in organisations' duty of care to workers whose health and safety they knew would be affected by the IPC guidance they published. This is for others to pursue.

And then lies and falsehoods had to be told to the Covid-19 Inquiry to maintain the reasons for the original sin back in March 2020. It is known what these are and by whom. The evidence is available, but no one to date has pieced it all together for the public. Hence the cover-up can continue.

It is known that the lie of March 2020, the original sin, was discussed by the UK Government IPC Cell. The UK Covid-19 Inquiry has received all sets of minutes of meetings of the IPC Cell, some members of which were involved in the original sin and have been involved in its cover-up since. But only 13 sets of minutes have been released into the public domain (and they had to be dragged out by FoI requests against strong resistance from the authorities). Even the Information Commissioner's Office had to get involved.

Around 120 sets of minutes were released to core participants at very short notice before the oral evidence of Dr Lisa Ritchie, who chaired the IPC Cell. This compromised the ability of core participants to question properly that witness about the IPC guidance. It is hoped that the Inquiry Chair will release these into the public domain once the module 3 report has been published.

SAGE, NERVTAG, ACDP and others all openly published their minutes in a relatively timely manner. Yet the secretive IPC Cell failed to publish any of their own volition and still haven't. So what is being covered up?

A new Government; and new Ministers at DHSC – a third report for information

The election of the Labour Government in July 2024 meant that a new set of Ministers had to be co-opted into the cover-up, most likely without their overt knowledge given they were inheriting the Covid policies of the previous Government. Government Ministers have written to other MPs as recently as April 2025 maintaining the lie of March 2020. There are four known letters, but it is expected there will be others.

The third of the reports [*The co-option into the cover-up of the new Government elected in July 2024*] explains these four letters signed by DHSC Ministers and why they are part of a cover-up, and also other letters from DfE Ministers that undermine the DHSC position. It brings the story up to date

A letter was authored for Andrew Gwynne to sign and send to Tim Farron in January 2025 repeating the fundamental lie that Covid is only transmitted through droplets, based on part of the testimony from Dr Lisa Ritchie at the Covid-19 Inquiry when she asserted that *"Covid is not predominantly transmitted through the aerosol route"*.

Another letter was sent from Ashley Dalton to Farron in March, which seemed to contradict that position, because, it is believed, it was authored by someone different; and then an

unsolicited letter three days later from Dalton to Farron which reverted to the March 2020 position that Covid was spread by droplets, seemingly once alarm bells had rung following Dalton's previous letter.

And then in April 2025, a letter was written for Dalton to sign and send to Andrew George MP, again repeating the knowingly erroneous position that Covid was spread by droplets.

The third report collates all the known evidence at the time these letters were sent and comprehensively shreds the premise in three of them that Covid-19 was spread by droplet.

Remember, after taking evidence from experts, Baroness Hallett confirmed in her Module 1 report (para 1.12) published in July 2024, *"…the primary routes of transmission for pandemic influenza and coronaviruses are airborne and respiratory…"*. This was published long before any of the letters were written and sent.
https://covid19.public-inquiry.uk/documents/module-1-full-report/

One of the letters urges caution about drawing conclusions from social media discussions and instead to rely on accepted global scientific evidence from such as the UKHSA, of which, of course, Jenny Harries was the Chief Executive. And at the Covid-19 Inquiry, Dame Jenny Harries agreed in her evidence in November 2024 that Covid-19 was transmitted via the airborne route potentially as well as via other routes.

As did Professor Chris Whitty. And in evidence to the Health and Social Care Select Committee on 5 March 2020, he is quoted as saying that Covid-19 is airborne (see page 3, para4):
https://committees.parliament.uk/oralevidence/113/pdf/

Expert after expert testified at the Inquiry that aerosol was the most likely route of spread of Covid-19. Which is why Baroness Hallett made the ruling she did after Module 1.

To undermine further the content of Andrew Gwynne's letter, in the Government's Independent report, 'COVID-19 and Occupational Impacts', published 16 November 2022, it states:

> *More recent evidence suggests that transmission from surfaces is less important and that droplet transmission is feasible only when individuals are in close proximity (SAGE-EMG, 2020a). The main route is airborne transmission through inhalation of aerosols (very fine particles suspended in air), which can be transmitted indoors over distances of several metres (Meyerowitz et al,. 2021; Stadnytskyi et al., 2021).*
> https://www.gov.uk/government/publications/covid-19-and-occupational-impacts/covid-19-and-occupational-impacts#transmission-of-and-exposure-to-sars-cov-2

Andrew Gwynne also states in his letter that the position described by Dr Ritchie aligns with the scientific evidence provided by the WHO. Except it doesn't. As well as earlier comments about the changed position of WHO, this document from WHO, published in March 2024, clearly states that airborne transmission of SARS-CoV-2 is significant:
https://iris.who.int/handle/10665/376346

The DHSC position was also undermined by two known letters from the Department for Education leading, it seems, to interventions by DHSC to prevent further such occurrences by

the DfE when the DHSC replied to an MP who had made an enquiry to the DfE about the use of air cleaning devices to help reduce school absences.

Final thoughts

That undercover decision of March 2020, to issue the CAS alert downgrading PPE from FFP3s to FRSMs, followed by the need to assert that Covid-19 had changed its mode of transmission from airborne to droplet, was possibly the single worst, and most consequential, decision taken in the history of the NHS. And it is being perpetuated.

It has led to a chain of events that have worsened the original decision to the point that those involved are unable to come clean. It keeps getting worse. You tell one lie and then have to keep telling increasingly complex lies in order to maintain the original sin. As Enid Blyton might say, it was the fib that grew bigger.

The fundamental lie of March 2020, the original sin, has become institutionalised, and the Government continues to break the law by mandating the use of illegal surgical masks which are not PPE.

With almost a quarter of a million UK citizens now dead, and maybe several million with earlier onset chronic health conditions caused by the lingering effects of the SARS-CoV-2 virus, including more than one in three healthcare workers, the implications for litigation are enormous – far in excess of the numbers involved with the Post Office and contaminated blood scandals.

Is it a fear of litigation that is driving the continuation of the lie? Is it simply a determination to protect reputations in an exercise that has now got bigger and bigger? Both? Or something else entirely?

It is always the cover-up of a sin that becomes the downfall. Cover-ups necessarily have to get more and more involved and complicated, and more and more people are drawn into them. Until eventually, it breaks open. This one is now creaking apart.